



Patient Label

<b>DIAGNOSTIC IMAGING</b> <b>OUTPATIENT SERVICES REQUISITION</b> <b>128 Lehua Street, Wahiawa 96786</b> <i>Revised 10/2021</i>	PATIENT'S LAST NAME:		FIRST NAME:	
	PHONE NUMBER:		DOB:	SEX:
	INSURANCE/PRE-AUTHORIZATION NUMBER:			
	<input type="checkbox"/> <b>WET READ</b>		<input type="checkbox"/> <b>STAT</b>	
Imaging Phone: (808) 621-4330 Fax Imaging Orders: (808) 621-4334 Mammography Phone: (808) 621-4177 Fax Mammogram Orders: (808) 621-4106	DATE OF SERVICE/APPOINTMENT:			
	DATE OF INJURY/ONSET:		LMP DATE:	
	<b>REQUIRED - ICD-10 Diagnosis Code:</b>			
	<b>REQUIRED - Type of Service/Procedure:</b>			
<b>REQUIRED</b> - Appropriate Use Criteria (AUC) Consultation (effective 1/1/22) - Mandatory for CT and NM:				
AUC Consult ID:				
CDSM Vendor:				
Score:				
Modifier:				
<b>DIAGNOSTIC IMAGING</b>				
<input type="checkbox"/> <b>X-RAY</b>		<input type="checkbox"/> <b>CT</b> <input type="checkbox"/> <b>CTA</b>		
<input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL		<i>COMPLETE CT DATA &amp; INDICATORS LISTED BELOW</i>		
<b>MAMMOGRAPHY</b>		<b>CT DATA</b>		
<input type="checkbox"/> Screening Mammo <input type="checkbox"/> RIGHT <input type="checkbox"/> Diagnostic Mammo <input type="checkbox"/> LEFT <input type="checkbox"/> BILATERAL		Date of Previous CT: _____ Is IV contrast required for the procedure? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> PER RADIOLOGIST Creatinine Results: _____ BUN Results: _____ <i>**Creatinine &amp; BUN Results MUST be within the past 60 days</i> HX of Adverse Drug Reaction to Contrast Media: <input type="checkbox"/> YES <input type="checkbox"/> NO Patient Taking Drug Glucophage (Metformin): <input type="checkbox"/> YES <input type="checkbox"/> NO <i>**If yes, the drug should be stopped at the time of or prior to the procedure and 48 hours after contrast media procedure.</i>		
<input type="checkbox"/> DEXA		<b>CT INDICATORS</b>		
<input type="checkbox"/> NUCLEAR MEDICINE		<input type="checkbox"/> Anemia <input type="checkbox"/> Comatose <input type="checkbox"/> Concussion <input type="checkbox"/> Drainage <input type="checkbox"/> GI Bleeding <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Jaundice <input type="checkbox"/> Lymph Nodes <input type="checkbox"/> Needle Aspiration <input type="checkbox"/> Needle Biopsy <input type="checkbox"/> New Onset Seizure <input type="checkbox"/> Therapy Planning <input type="checkbox"/> TIA <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____		
<input type="checkbox"/> ULTRASOUND		<b>SPECIAL INSTRUCTIONS</b>		
<input type="checkbox"/> OTHER: _____		<input type="checkbox"/> Patient to Return with Films/CD <input type="checkbox"/> Patient may Leave; Return to My Office; Send films/CD to my Office <input type="checkbox"/> Send Results By: FAX# _____ PHONE # _____		
<b>PATHOLOGY (If indicated for Biopsy)</b>				
<input type="checkbox"/> Pathology/Cytology				
Site:				

Signature: \_\_\_\_\_, MD Print Name: \_\_\_\_\_, MD Date: \_\_\_\_\_

*Notification to Physicians and Other Persons Legally Authorized to Order Tests for Which Medicare Reimbursement Will Be Sought. Medicare will pay only for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Medicare does not pay for tests for which documentation, including the patient record, does not support that the tests were reasonable and necessary. Medicare generally does not cover routine screening tests. Complete the ABN for tests that Medicare will not consider "medically necessary" for the noted diagnosis. Procedures governed by local or national coverage determination (LCD or NCD) are found in the Medicare A and Medicare B publications and listed on their respective websites: www.iamedicare.com (Part A) and www.noridianmedicare.com (Part B).*